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CASE REPORT

Continuity of Midwifery Care for Mrs. P at the Ibrahim Adjie Community Health Center, Bandung City

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Abstrak: Continuity of midwifery care is holistic care that builds trusting relationships, understands women's needs, and empowers them in their reproductive health care. Pregnancy, childbirth, postpartum, and breastfeeding are fundamentally physiological processes, but they can lead to discomfort. Midwives strive to help address these issues. This report aims to demonstrate continuity of midwifery care through the application of warm compresses to address discomfort occurring during pregnancy and postpartum. This report uses a case study method. Data collection was conducted from July to November 2024 at the Ibrahim Adjie Community Health Center in Bandung City. The results of continuous midwifery care for Mrs. P revealed lower abdominal pain that occurred during the third trimester of pregnancy. The delivery process was also closely related to physiological pain, which proceeded normally without complications. In the postpartum period, complaints of pain or afterpain were reported. Untreated pain can lead to anxiety and stress. Warm compresses are one method that can reduce pain simply without side effects and is in accordance with the midwife's competence. The application of warm compresses is an effective and safe non-pharmacological method for managing pain complaints during pregnancy, childbirth, and the postpartum period.

Keywords: continuity of midwifery care, pain, warm compresses

INTRODUCTION

Pregnancy, childbirth, postpartum, and breastfeeding are essentially physiological and natural processes. During the third trimester, one physical change occurs is lower abdominal pain, which makes it difficult for mothers to carry out activities, especially in later pregnancy. Lower abdominal pain is caused by hypertrophy or stretching, accompanied by pressure and the descending fetal head, which puts pressure on the lower abdominal ligaments.[1] Furthermore, fatigue, poor body mechanics, and the activities undertaken by pregnant women can also trigger complaints. Lower abdominal pain is a common complaint in Indonesia, with a prevalence rate of 49%. 80-90% of pregnant women

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with lower abdominal pain report taking no action to manage or relieve the pain, and only 10-20% of pregnant women consult a healthcare professional for pain management.[2]

After pregnancy, the mother will enter labor. This indicates that the physiological and psychological adaptations of pregnancy can determine the mother's readiness for labor.[3] As many as 15% of mothers in Indonesia experience complications during childbirth, 21% said that their labor was very painful and 63% were unsure about the preparations needed to reduce pain during labor.[4] The labor process is closely associated with physiological pain. This pain occurs when the uterine muscles contract, opening the cervix and pushing the baby's head toward the pelvis.[5] One non-pharmacological method for labor pain relief is the application of warm compresses. The mechanism of action is similar to that used to address discomfort during pregnancy. The effects of warm compresses on the body include increased blood flow to the painful area, muscle relaxation, and pain relief from spasms, as well as increased blood flow and improved nutrition.[5] Warm compresses applied to the lower abdomen and back can make the mother feel more comfortable and calmer in facing the labor process.[6]

After experiencing the process of pregnancy and childbirth, a mother will enter the postpartum period, which is a transitional period where physical and psychological changes occur.[3] During this period, uterine involution occurs, accompanied by contractions, which can cause pain, also known as afterpain. Research indicates that the incidence of spontaneous vaginal births worldwide is 79%, which can increase the risk of afterpain in the postpartum period.[7] According to report by the World Health Organization (WHO), the prevalence of postpartum pain due to childbirth in Indonesia is quite high, at around 86.8%. Afterpain is described as cramping, strong pulling, or even stabbing. Afterpain is caused by uterine ischemia during uterine contractions. Besides uterine involution, another cause of afterpain is breastfeeding. During breastfeeding, oxytocin is released, which causes uterine contractions, accelerating uterine involution.[8]

To help mothers adapt to the pain they experience during pregnancy, childbirth, and postpartum, pharmacological and non-pharmacological methods can be used. While pharmacological techniques are more effective, they are relatively expensive and potentially have adverse effects compared to non-pharmacological techniques, which are cheaper, simpler, and have no adverse effects.[9] One non-pharmacological therapy that can be given is a warm compress. Warm compresses are a procedure to reduce pain by providing heat energy through the process of conduction, where heat can cause vasodilation (widening of blood vessels) thereby increasing oxygen, nutrients, and blood leukocytes to the body's tissues. Warm compresses on certain areas will increase circulation in that area, followed by increased metabolic activity throughout the

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body, smoother blood flow supply, induce sweating, and relax the tissues so that the heat transmitted through the warm compress can relieve pain. Non-pharmacological therapy can stimulate thermoreceptors in the skin and deeper tissues and can reduce pain.[10]

To support the physiological adaptation process experienced by mothers, we need competent midwives. Qualified midwives are those with extensive and professional knowledge and skills.[11] The philosophy of the continuity of care model emphasizes natural conditions, namely helping women to be able to give birth with minimal intervention and monitoring of the physical, psychological, spiritual and social health of women and their families.[12] The midwifery profession plays a vital role in maintaining women's health and well-being throughout their lives. Therefore, the professional skills of midwives are crucial for empowering women. As science advances, society increasingly demands better quality healthcare, particularly in the field of midwifery.[11]

Continuity of midwifery care starting from pregnancy, childbirth, postpartum, neonates and baby as well as family planning services is very important to be carried out, especially by midwives, so that they can provide quality services and prevent maternal and child deaths.[12] Based on this background, it can be concluded that the problem formulation is "How is the continuity of midwifery care for Mrs. P at the Ibrahim Adjie Community Health Center in Bandung City?"

METHOD

This report uses a case study method. The practice of continuous midwifery care was carried out at the Ibrahim Adjie Community Health Center in Bandung City from July to November 2024. The subjects were analyzed comprehensively from various aspects according to midwifery management from pregnancy, childbirth and postpartum period according to evidence-based. The subjects in this case report are Mrs. P, 30 years old, G3P2A0, 35 weeks of gestation who were given care until the postpartum period of 6 weeks and newborn babies from 0 to 2 months 11 days old.

Data collection techniques used primary and secondary data. Primary data were obtained from interviews and observations conducted during midwifery care. Secondary data were obtained from documentation, including KIA books, pregnancy registers, and patient medical records.

In compiling this report on continuous midwifery care, the author paid attention to several ethical issues that might occur during the provision of midwifery care, namely respect for person, beneficence and non-maleficence, and justice.

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RESULTS AND DISCUSSION

1. Pregnancy Care

Ms. P's continuous midwifery care began in the third trimester of pregnancy (35 weeks) and continued until 6 weeks postpartum. During her pregnancy, Ms. P underwent 13 examinations, two of which were ultrasound examinations by an obstetrician in the first and third trimesters, exceeding the minimum recommendations from the Ministry of Health (6 times) and the WHO (8 times).[13] The author conducted three in-person visits: at 35 weeks, 37 weeks, and 39 weeks and 2 days of gestation. These additional visits were based on Mrs. P's complaints of discomfort, necessitating special monitoring and further detection of complications. Detection during prenatal checkups significantly assists in risk management preparation, in line with a midwife's role in providing promotive and preventive measures.[14]

The focus of care shifts according to the stage of pregnancy. In the first trimester, the goal is to ensure the health of the mother and fetus, detect risks early, and the midwife begins to build a therapeutic relationship with the mother and family. The second trimester focuses on monitoring fetal growth and development and detecting complications, while the midwife facilitates discussions about delivery options and birth plans. In Mrs. P's case, the focus of care during the second visit was to address the mother's discomfort by providing information, communication, and education and interventions such as warm compresses using hot gel packs, as well as evaluating the care provided previously. In the third trimester, care becomes more intensive, focusing on labor preparation.

One of the discomforts successfully addressed was Mrs. P.'s lower abdominal pain. This pain was caused by ligament stretching due to the enlarging uterus. To address this, the author recommended that the mother remain calm, teach body mechanics, and apply warm compresses. Warm compresses work by dilating blood vessels, increasing blood flow, and reducing muscle tension, effectively alleviating pain.[1] A hot gel pack dipped in warm water and used as a warm compress is a good source of warmth. The water temperature used for the compress is 38-40ºC. Research has shown that the most effective compress duration is approximately 20-30 minutes.[5] After being evaluated, the pain felt by the mother decreased, and she was able to adapt to the complaint.

2. Childbirth Care

After a well-managed pregnancy, Mrs. P entered labor. The heartburn she experienced signaled the beginning of the journey toward birth. To cope with the pain and anxiety that arose, the mother empowered herself to return to non-pharmacological methods, namely warm compresses. This technique, similar to

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that used during pregnancy to address discomfort, effectively increases blood flow, relaxes muscles, and reduces pain.[5] The application of warm compresses successfully reduced Mrs. P's pain scale from 6 (moderate) to 3 (mild). This is supported by research by Rini et al., which found that applying warm compresses is effective in reducing pain during labor, reducing the mother's pain and making her feel calmer.[6]

Mrs. P arrived at the community health center with a cervical dilation of 8 cm, indicating she was in the active phase of the first stage of labor, which lasted for 2 hours. The baby boy was born spontaneously and immediately received basic essential neonatal care. The second stage lasted 35 minutes. Active management of the third stage was then implemented, and the placenta was successfully delivered within 10 minutes.

The quality of the birth experience is greatly influenced by the support received. Consequences of a positive birth experience include increased self-esteem, self-efficacy, skills, mother-infant bonding, and increased acceptance of the mothering role. A qualitative study of positive birth experiences found that the environment plays a significant role in birth satisfaction. Most mothers felt safe and better able to manage their emotions during labor because they were accompanied by their partners, relatives, and midwives.[4]

In Mrs. P's case, her husband's presence as a birth companion was crucial. He not only accompanied her but also provided positive affirmations as a form of emotional support that helped the mother manage her emotions, allowing her to maintain a relaxed and positive state of mind during labor. Furthermore, support from the care provider or midwife was also crucial. Women's perceptions of the quality of midwifery care during childbirth increase their comfort. These qualities include the midwife's reassurance, caring, and kindness. A good midwife should possess compassion, empathy, and good communication skills, be knowledgeable, supportive, and skilled. The ICM (International Confederation of Midwives) midwifery service philosophy emphasizes caring, respect, flexibility, and anticipatory response to the needs of women, babies, families, and communities. A professional midwife has a positive concern and partnership with women giving birth and their families and develops herself personally and professionally.[15]

Based on the care provided during labor, women's empowerment is key to a positive birth experience. Empowering women allows them to be more involved in decision-making about caring for themselves and their babies, allowing them to gain greater control and self-management. The care provided is also appropriate to the conditions and needs,

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using non-pharmacological methods accompanied by holistic support, which makes Mrs. P feel comfortable, calm, and confident.

3. Postpartum Care

The care phase continues into the postpartum period for the next six weeks. The main focus in this phase is the psychological adaptation and physical recovery of the mother. Psychologically, Mrs. P showed good adaptation to her new role as a mother. She passed the taking-in phase (passive postpartum phase) with full support from her husband and family, and immediately moved to the taking-hold phase (days 3 to 10) where she began to be more confident in caring for her baby and taking control of her role. Supported by the theory of Maternal Role Attainment and Becoming a Mother by Ramona T. Mercer which focuses on the continuous and dynamic process of becoming a mother. Mercer emphasized that motherhood is a dynamic process and develops over time influenced by various factors such as social support, previous experiences, physical and mental health and the characteristics of the baby.[16]

Based on the 2018 Basic Health Research (Riskesdas), the prevalence of postpartum depression in Indonesia reached 15.6% and most cases began with baby blues which occurred within 4-5 days after giving birth.[17] Early detection of mental disorders, such as postpartum depression, was conducted using the SRQ-20 at the first postpartum visit, and Mrs. P received a low score, indicating no indication of mental disorders. This is in line with research conducted by Ariani et al., as cited in the Scientific Journal of Health Sciences, which found that mothers with support from their husbands significantly helped postpartum mothers navigate their psychological adaptation phase happily and smoothly.[18]

Physically, Mrs. P's main complaint was a feeling of heartburn in the stomach, or what is called afterpains, which was caused by the process of uterine involution (return of the uterus to its original size).[19] The author provides counseling on the mechanism of this involution, which is naturally accelerated by the production of the hormone oxytocin. This oxytocin is strongly stimulated by the baby's sucking during Early Initiation of Breastfeeding (IMD) and exclusive breastfeeding.[20] This complaint of heartburn is again addressed with a method that has been proven effective during pregnancy and childbirth, namely warm compresses, which work by increasing circulation and relieving pain.[21]

The author's role as a midwife during postpartum visits is to provide continuous support throughout the postpartum period, tailored to the mother's needs, to minimize physiological and psychological complications. Midwives promote a close bond between mother

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and baby, encouraging mothers to breastfeed by increasing their comfort.[22] In this regard, based on research conducted by Asmuji et al., one approach is to develop a Postnatal Education Model focused on postpartum mothers and involving the family. This model has the advantage of optimizing the mother's understanding of her role and function in maternal adaptation and newborn care, with the family actively involved in these efforts. Consequently, the mother will develop optimally competent mothering skills.[23] Mrs. P's recovery is also supported by meeting basic needs, such as adequate rest, balanced nutrition, and early mobilization to help uterine contractions and speed up recovery.

Mrs. P received balanced counseling and remained steadfast in her choice to become an IUD user, fully supported by her husband. Research conducted by Lisnawati et al. on the influence of husband's support on the choice of IUD contraception revealed that husband's support influences the choice of IUD contraception. The support provided by a husband is a tangible manifestation of his care and responsibility. One form of husband's support is participating in choosing a contraceptive that suits his wife's condition, accompanying his wife during family planning counseling and check-ups.[24] At the fourth postpartum visit, after Mrs. P's physical condition was declared normal, the IUD was successfully inserted, completing the entire series of holistic and continuous care from pregnancy, delivery, to the establishment of a long-term contraceptive method.

4. Neonatal and Infant Care

Care begins immediately after delivery with Basic Essential Neonatal Care, where Early Initiation of Breastfeeding (IMD) acts as a direct bridge to the postpartum phase. Through skin-to-skin contact, the baby receives colostrum for protection and stimulates the mother's production of the hormones prolactin and oxytocin. These hormones are vital for preventing postpartum hemorrhage, accelerating uterine involution, and increasing breast milk production.[25] Thus, successful treatment of the baby directly supports Mrs. P's physiological recovery.

During the postpartum period, infant care centers on supporting exclusive breastfeeding. When Mrs. P expressed concern about low breast milk production at the second neonatal visit (4 days old), immediate intervention was provided through counseling and a recommendation for oxytocin massage. This action successfully resolved the lactation problem, ensuring the baby received optimal nutrition. Conversely, the baby's strong suction further accelerated the mother's uterine contractions, relieving the afterpains she had experienced. A mother's efforts to continue breastfeeding her baby begin

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with a strong intention or desire to provide breast milk for her baby. Strong family dynamics will also affect the mother's physical and mental health, facilitating and increasing breast milk production because, with the support of loved ones, a breastfeeding mother will strive to create a comfortable atmosphere within the family. Conversely, if the mother feels anxious, stress will interfere with breast milk production.[18] This consistency in lactation care is reflected in the monitoring of infant growth, where infants who had experienced physiological weight loss at the initial visit, successfully achieved their birth weight again and showed healthy growth at subsequent visits, proving the success of integrated care.

As an integral part of the preventive health program, neonatal care also includes screening for congenital heart disease (CHD), which is a structural abnormality of the heart and blood vessels that appears from birth and can occur due to two factors, namely genetic factors and environmental factors. Genetic factors include hereditary influences or a history of disease in the family and certain syndromes due to an abnormal number of chromosomes (trisomy 21, trisomy 13,18) such as Down syndrome. Environmental factors include maternal rubella virus infection, use of teratogenic drugs during pregnancy and excessive alcohol consumption (maternal alcohol abuse).[26] The Indonesian Pediatrician Association (IDAI) has recommended checking oxygen saturation with a pulse oximeter for every healthy baby aged 24-48 hours or before being discharged.[27] This aligns with actual findings, where Mrs. P's baby was screened for congenital heart disease (CHD) before being discharged from the community health center. Furthermore, congenital hypothyroidism (CHD) screening was performed 24 hours after birth. Congenital hypothyroidism (CH) is a condition in which the thyroid gland is absent or has decreased function since birth.[28]

An early detection measure aimed at protecting the baby's growth and development potential, which has been prepared since pregnancy. Furthermore, routine growth monitoring (weight, length, head circumference) and evaluation of primitive reflex development during immunization visits at 1 and 2 months ensure optimal nervous system development. Thus, the midwifery care provided to Mrs. P and her baby represents a perfect cycle, starting from healthy pregnancy preparation, safe delivery, postpartum physical and psychological recovery, to ensuring optimal nutrition and development for the baby, all of which are continuously connected.

CONCLUSION

Mrs. P's midwifery care demonstrated the successful implementation of Midwife-Led Continuity of Care (MLCC), affirming

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midwives as the right healthcare professionals to provide ongoing care to women. One such approach is the Continuity of Information, where information and care are continuously evaluated from the first contact to empower clients. This is perfectly reflected in the Continuity of Management warm compress intervention introduced during Mrs. P's pregnancy to address discomfort and empower clients to reuse it independently when dealing with labor pain and postpartum afterpains. This cycle creates optimal outcomes, a healthy pregnancy, a positive birth experience, postpartum recovery supported by successful lactation and comprehensive neonatal and baby care, ensuring maximum and sustainable maternal and neonatal health.

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